DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		15E247	A. BUILI B. WING			05/26/2	2011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 17TH AVENUE BEECH GROVE, IN46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
F0000							
F0000	State Licensure S Survey Dates: May Facility Number: 00 Provider Number: 1 AIM Number: 1002 Survey Team: Leia Alley, RN, TC Patti Allen, BSW Marcy Smith, RN Rhonda Stout, RN (Census Bed Type: NF: 47 Residential: 51 Total: 98 Census Payor Type: Medicaid: 28 Other: 70 Total: 98 Sample: NF: 13 Residential: 5	23, 24, 25, & 26, 2011 00391 5E247 274990 May 25 and 26, 2011) also reflect state findings cited 410 IAC 16.2. pleted 6/6/11	F00	000			
	Court Embwilet MV						
LABORATOR	Y DIRECTOR'S OR PROV	TIDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

0QUP11

Facility ID:

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15F 247		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/26/2011	
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE ORTH 17TH AVENUE	
ST PAUL	. HERMITAGE		BEECH	I GROVE, IN46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	resident; consult wand if known, notified regarding bowel movement	s in either life threatening all complications); a need to inificantly (i.e., a need to sting form of treatment due uences, or to commence a nent); or a decision to ge the resident from the d in §483.12(a). Iso promptly notify the pown, the resident's legal interested family member ange in room or roommate excified in §483.15(e)(2); or ant rights under Federal or attions as specified in	F0157	Resident #967A. Current constipation care plan has be reviewed by MDS RN, DON, Unit Manager and hospice R and determined appropriate ongoing for this resident. Completed 5/31/11B. Curren	or N and

STATEMEN	NT OF DEFICIENCIES	S X1) PROVIDER/SUPPLIER/CLIA (2		(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIT	I DDIG	00	COMPL	ETED
		15E247		LDING		05/26/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R		1			
OT DALU	LIEDANTAGE			1	PRTH 17TH AVENUE		
STPAUL	_ HERMITAGE			BEECH	I GROVE, IN46107		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	sample of 13. (F	Residents #967, #1010 and			bowel management medica		
	#779)	•			regimen has been reviewed		
	, , , ,				MD, DON, or Unit Manager		
	Findings included:				hospice RN and determined		
					appropriate and ongoing for		
					resident. Completed 5/31/11		
	An undated faci	lity policy, titled Bowel			Resident's constipation care	pian	
	Management, re	eceived from the Director			and bowel management medication regimen has bee	n .	
	of Nursing (Dol	N) on 5/25/11 at 8:45 a.m.			reviewed with medication	51 I	
	1	rent, indicated "Policy:			administration(charge) nurse	es.	
		•			Completed 5/31/11D. Nursi		
		y] nursing personnel will			staff(licensed nurses and	Ü	
		vel elimination pattern of			CNA's) will be inserviced to	Bowel	
	each resident. P	Purpose: To allow each			Management Policy and		
	resident to main	tain their normal, regular			procedures with emphasis of		
	bowel elimination	on schedule thereby			documentation and reporting	g.	
		tipationProcedure:7.			Completed by 6/25/11E.		
	1 -	e notified and order			Resident's Elimination Track	king	
	1 *				and bowel management medication MAR forms have		
	1	propriate treatment if no			been monitored by DON and		
		I [bowel movement] in			Manager and found accurate		
	three days. 8. (Charge nurse will			complete since date of	o una	
	administer phys	ician ordered treatment if			deficiency.Resident #1010A		
	no documented	BM in three days"			Current constipation care pla	an	
		,			has been reviewed by MDS	RN,	
	1 The record of	Resident #967 was			DON, or Unit Manager and		
	1	4/11 at 11:40 a.m.			determined appropriate and		
					ongoing for this resident.		
	1 ~	esident #967 included,			Completed 5/31/11B. Curre		
	but were not lim	nited to, constipation and			bowel management medical regimen has been reviewed		
	dementia.				MD, DON, or Unit	DУ	
					Manager determined approp	oriate	
	A constination of	eare plan for the resident,			and ongoing for this residen		
	_	rough 6/9/11, indicated a			Completed 5/31/11C. Resid		
					constipation care plan and b		
	1 -	ent's name] will have a			management medication reg		
		nt at least 1 every 3 days			has been reviewed with		
	1	90 days. Interventions			medication		
	included "The n	urse will administer stool			administration(charge) nurse	es.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		15E247	B. WIN			05/26/2	011
		1	D. (/11		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	3			RTH 17TH AVENUE		
ST PALII	_ HERMITAGE			BEECH GROVE, IN46107			
				<u> </u>	GROVE, 114-0107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	softeners or laxa	tives per [Resident's			Completed 5/31/11D. Nursin	ng	
	name] usual scho	edule with the physician's			staff(licensed nurses and		
	order. The nurse	e will monitor the			CNA's) will be inserviced to I	Bowei	
		the medication and			Management Policy and procedures with emphasis or	n	
		Resident's name] chart.			documentation and reporting		
	1				Completed by 6/25/11E.		
	1	ill be notified and an			Resident's Elimination Track	ina	
		or appropriate treatment if			and bowel management	5	
	[Resident's name	e] has had no			medication MAR forms have		
	documentation of a bowel movement in 3 days. The charge nurse will administer physician's ordered treatment if no				been monitored by DON and		
					Manager and found accurate	and	
					complete since date of		
	1 ^ *	of a bowel movement in 3			deficiency.Resident #779A.		
		or a dower movement in 5			Current constipation care pla		
	days"				has been reviewed by MDS	RN,	
					DON, or Unit Manager and determined appropriate and		
	Recapitulated ph	nysician's orders for April,			ongoing for this resident.		
	2011, indicated 1	Resident #967 could			Completed 5/31/11B. Currel	nt	
	receive the follo	wing.			bowel management medicat		
		···			regimen has been reviewed		
	Cologo 100 mg ((milliamama) 1 aamayla			MD, DON, or Unit		
	1	(milligrams) 1 capsule			Manager determined approp		
	1 *	for constipation (original			and ongoing for this resident		
	order dated 2/28				Completed 5/31/11C. Resid		
	Colace 100 mg 2	2 capsules daily as needed			constipation care plan and b		
	for constipation	(original order dated			management medication reg	ımen	
	2/28/09)				has been reviewed with medication		
	1 ′	ycol 17 grams mixed in 5			administration(charge) nurse	ie.	
	1 .	-			Completed 5/31/11D. Nursir		
	1 ^	I daily as needed for			staff(licensed nurses and	.9	
	constipation (ori	ginal order dated 6/29/10.			CNA's) will be inserviced to I	Bowel	
					Management Policy and		
	Review of an El	imination Tracking			procedures with emphasis o		
	Record for Apri	1, 2011, indicated the			documentation and reporting	J.	
	1	have a bowel movement			Completed by 6/25/11E.	_	
					Resident's Elimination Track	ing	
	from 4/17/11 thr	ougn 4/20/11.			and bowel management		
					medication MAR forms have		
	Review of Medi	cation Administration			been monitored by DON and	Unit	

STATEMEN	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED		
		15E247				05/26/2	011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIE	R		1				
OT DALI	LIEDMITAGE			1	PRTH 17TH AVENUE			
ST PAUL	HERMITAGE			REECH	I GROVE, IN46107			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Records for Apr	il, 2011, indicated the			Manager and found accurate	e and		
	resident did not	receive the above laxative			complete since date of			
	medications (Co	place and Polyethylene			deficiency.Due to overall ge	neral		
		ed for constipation			debility all Health Center residents will be considered			
	1 * '	•			potentially affected by this	as		
	between 4/17/11	and 4/28/11.			deficiency and subject to the	2		
					facility's Bowel Managemen			
	There was no do	ocumentation to indicate			policy and procedures:A. C			
	the physician ha	d been notified of the			will document on each shift			
	resident's lack o	f bowel movements			all resident's BMs on the	•		
	during this 12 da				Elimination Tracking Record			
	during this 12 di	uy period.			notify the charge nurse if no			
	F 4 . C	. 10			in three(3) days.B. Charge	nurse		
		tion was requested from			will administer the			
		5/11 at 7:00 p.m.			physician-ordered bowel			
	regarding Resid	ent #967's lack of BM's or			medication and document o			
	treatments between	een 4/17/11 through			MAR if no BM in three (3) do notify the MD to obtain	ays or		
	4/28/11.	-			appropriate bowel medication	n if		
					no medication currently	,,,,,,		
	Daning internal	5/26/11 at 10:20 a m			ordered.C. Charge nurse w	ill		
	1	w on 5/26/11 at 10:30 a.m.			document results of ordered			
		ed she had no further			bowel medication on the MA	۸R		
	1	provide and she would be			and notify MD if no results			
	providing some	education to staff			obtained following resident's			
	regarding bowel	protocol.			receipt of ordered med.D. A			
		•			residents will be care planne			
	2 The record of	f Resident #1010 was			regarding constipation or po			
	1				for constipation.1. Current E	Bowei		
	reviewed on 5/2	5/11 at 3:55 p.m.			Management policy and procedures have been revie	wed		
					and revised, including clarifi			
	Diagnoses for R	esident #1010 included,			of Procedure #7 to prevent f			
	but were not lim	nited to, constipation and			misinterpretation.(See Bowe			
	spinal stenosis.				Management policy that was			
	*				uploaded to this			
	A care plan with	an onset of 8/11/10 and			report)Completed 6/6/112.	All		
	1 -				nursing staff(licensed			
	1	7/14/11 indicated the			nurses/CNAs) to be inservice			
		risk for constipation due			new Bowel Management po			
	I to decreased act	ivity. The goal was that			and procedures by 6/25/113	.		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00 CO	MPLETED
15E247 A. BUILDING 05/3	26/2011
B. WING STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 511 NORTH 17TH AVENUE	
ST PAUL HERMITAGE BEECH GROVE, IN46107	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
she would have a bowel movement at Night charge nurses will reveiw	DATE
least every 3 days "as seen by the nightly each resident's Elimination	
do our contation in her about within the provider and addition to day	
90 days." Interventions included "The and evening charge nurses to monitor documentation and	
nurse will administer stool softeners or prevent deficiency recurrence.	
layatives per [resident's name] usual Begun 6/6/114. DON and Unit	
Manager will monitor Elimination	
nurse will monitor the effectiveness of the Tracking form and MAR weekly for three (3) months. Begun	
medication and document it in [resident's 6/14/115. Deficiency and	
name] chart. The physician will be corrective measures presented to	
notified and an order obtained for QA committee on 6/21/11 by DON and will be reviewed quarterly for	
appropriate treatment if [Resident's name] one(1) year by DON and	
has had no documentation of a bowel committee.6. All charge nurses	
movement in 3 days." will be counseled with written	
disciplinary reports by 6/25/11.7. MDS RN will review all residents	
Recapitulated physician's orders for May, and develop care plan for each	
2011, indicated the resident could receive regarding constipation/elimination	
Milk of Magnesia (a laxative) 30 needs.	
milliliters once a day as needed for	
constipation. (original order date 9/25/08)	
Review of an Elimination Tracking	
Record for March, 2011, indicated	
Resident #1010 did not have a bowel	
movement 3/12/11 through 3/16/11.	
Review of Medication Administration	
Records for March 2011 did not indicate	
the resident received any Milk of	
Magnesia between 3/12/11 through	
3/16/11.	
There was no documentation to indicate	
the physician had been notified of the	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLETED	
		15E247	B. WIN			05/26/20	11
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF E	PROVIDER OR SUPPLIER			501 NO	RTH 17TH AVENUE		
	. HERMITAGE				I GROVE, IN46107		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	.	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)	+	DATE
		bowel movements					
	during this 5 day	period.					
		ion was requested from					
	the DoN on 5/25	•					
	1	ident's lack of BM's or					
	treatment betwee	en 3/12/11 and 3/16/11.					
		on 5/26/11 at 10:30 a.m.					
	the DoN indicated she had no further						
	information to pr	ovide and she would be					
	providing some	education to staff					
	regarding bowel	protocol.					
	The record for R	esident #779 was					
	reviewed on 5/26	6/11 at 1:30 p.m.					
		led, but are not limited to,					
		mfort secondary to weak					
		nuscle, gastroparesis (a					
		duces the stomach's					
		it's contents), mild					
	irritable bowel sy						
	i iiiiabic bowei sy	riui oilie.					
	A reconitulated n	hysicians order for May,					
		esident #779 had a PRN					
	l ` ′	r for Milk of Magnesia					
	1 *	30 mls by mouth, once a					
	day for constipat	10n.					
	Am UElimain at	Tradring Dagardll Courts					
		Tracking Record" for the					
		2011, indicated Resident					
		a bowel movement (BM)					
	I	March 8th to March					
		I indicated the resident					
	went 8 days with	out a BM. There were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15E247		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/26/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 17TH AVENUE BEECH GROVE, IN46107					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	in regards to the	cations to the physician residents lack of bowel ck of prn medications not ed.						
	(MAR) for the m reviewed. The M	Administration Record" nonth of March, 2011 was MAR indicated Resident eived any Milk of astipation.						
	at 3:00 p.m., furt requested in rega tracking. The Do was not properly elimination and ravailable in regar movements or th	g administered and						
F0282 SS=D	facility must be pro in accordance with plan of care. Based on record	ded or arranged by the ovided by qualified persons a each resident's written review and interview, to ensure protocol and	F0282	Resident #967A. Current constipation care plan has b reviewed by MDS RN, DON				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15F247 05/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 501 NORTH 17TH AVENUE ST PAUL HERMITAGE BEECH GROVE, IN46107 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Unit Manager and hospice RN care plans for bowel management were and determined appropriate and followed for 3 of 7 residents reviewed for ongoing for this resident. bowel management in a sample of 13. Completed 5/31/11B. Current (Residents #967, #1010 and #779) bowel management medication regimen has been reviewed by MD, DON, or Unit Manager and Findings included: hospice RN and determined appropriate and ongoing for this An undated facility policy, titled Bowel resident. Completed 5/31/11C. Management, received from the Director Resident's constipation care plan and bowel management of Nursing (DoN) on 5/25/11 at 8:45 a.m. medication regimen has been and deemed current, indicated "Policy: reviewed with medication [name of facility] nursing personnel will administration(charge) nurses. monitor the bowel elimination pattern of Completed 5/31/11D. Nursing staff(licensed nurses and each resident. Purpose: To allow each CNA's) will be inserviced to Bowel resident to maintain their normal, regular Management Policy and bowel elimination schedule thereby procedures with emphasis on documentation and reporting. preventing constipation...Procedure:...7. Completed by 6/25/11E. Physician will be notified and order Resident's Elimination Tracking obtained for appropriate treatment if no and bowel management documented BM [bowel movement] in medication MAR forms have three days. 8. Charge nurse will been monitored by DON and Unit Manager and found accurate and administer physician ordered treatment if complete since date of no documented BM in three days..." deficiency.Resident #1010A. Current constipation care plan 1. The record of Resident #967 was has been reviewed by MDS RN, DON, or Unit Manager and reviewed on 5/24/11 at 11:40 a.m. determined appropriate and ongoing for this resident. Diagnoses for Resident #967 included, Completed 5/31/11B. Current but were not limited to, constipation and bowel management medication regimen has been reviewed by dementia. MD, DON, or Unit Manager determined appropriate A constipation care plan for the resident, and ongoing for this resident. dated 3/16/11 through 6/9/11, indicated a Completed 5/31/11C. Resident's constipation care plan and bowel goal of "[Resident's name] will have a

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 15F247 05/26/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 501 NORTH 17TH AVENUE ST PAUL HERMITAGE BEECH GROVE, IN46107 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE bowel movement at least 1 every 3 days management medication regimen has been reviewed with within the next 90 days. Interventions medication included "The nurse will administer stool administration(charge) nurses. softeners or laxatives per [Resident's Completed 5/31/11D. Nursing staff(licensed nurses and name] usual schedule with the physician's CNA's) will be inserviced to Bowel order. The nurse will monitor the Management Policy and effectiveness of the medication and procedures with emphasis on document it in [Resident's name] chart. documentation and reporting. The physician will be notified and an Completed by 6/25/11E. Resident's Elimination Tracking order obtained for appropriate treatment if and bowel management [Resident's name] has had no medication MAR forms have documentation of a bowel movement in 3 been monitored by DON and Unit days. The charge nurse will administer Manager and found accurate and complete since date of physician's ordered treatment if no deficiency.Resident #779A. documentation of a bowel movement in 3 Current constipation care plan days..." has been reviewed by MDS RN, DON, or Unit Manager and determined appropriate and Recapitulated physician's orders for April, ongoing for this resident. 2011, indicated Resident #967 could Completed 5/31/11B. Current receive the following: bowel management medication regimen has been reviewed by MD. DON. or Unit Colace 100 mg (milligrams) 1 capsule Manager determined appropriate daily as needed for constipation (original and ongoing for this resident. order dated 2/28/09) Completed 5/31/11C. Resident's Colace 100 mg 2 capsules daily as needed constipation care plan and bowel management medication regimen for constipation (original order dated has been reviewed with 2/28/09) medication Polyethylene Glycol 17 grams mixed in 5 administration(charge) nurses. - 8 ounces liquid daily as needed for Completed 5/31/11D. Nursing staff(licensed nurses and constipation (original order dated 6/29/10. CNA's) will be inserviced to Bowel Management Policy and Review of an Elimination Tracking procedures with emphasis on Record for April, 2011, indicated the documentation and reporting. Completed by 6/25/11E. resident did not have a bowel movement

l ´		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15E247	B. WIN	IG		05/26/2	011
NAME OF	PROVIDER OR SUPPLIER	}	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
TVIIVIL OI	I ROVIDER OR SOLITEIE			501 NO	RTH 17TH AVENUE		
ST PAUL	_ HERMITAGE			BEECH	GROVE, IN46107		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	from 4/17/11 thr	ough 4/28/11.			Resident's Elimination Track	ing	
					and bowel management medication MAR forms have		
	Review of Medi	cation Administration			been monitored by DON and		
	Records for April	il, 2011, indicated the			Manager and found accurate		
	1	receive the above laxative			complete since date of		
	1	lace and Polyethylene			deficiency.Due to overall ger	neral	
		ed for constipation			debility all Health Center		
	between 4/17/11	•			residents will be considered	as	
	DELWEEH 4/1 //11	anu 4/20/11.			potentially affected by this deficiency and subject to the		
There was no documentation to indicate the physician had been notified of the					facility's Bowel Management		
					policy and procedures:A. Cl		
					will document on each shift of		
	resident's lack of bowel movements				all resident's BMs on the	-	
	during this 12 da	ny period.			Elimination Tracking Record		
					notify the charge nurse if no		
	Further informat	ion was requested from			in three(3) days.B. Charge r will administer the	nurse	
		5/11 at 7:00 p.m.			physician-ordered bowel		
	1	ent #967's lack of BM's or			medication and document or	n the	
	1	een 4/17/11 through			MAR if no BM in three (3) da		
	4/28/11.	on 4/1//11 through			notify the MD to obtain		
	7/20/11.				appropriate bowel medicatio	n if	
	During internit	er on 5/26/11 at 10:20 =			no medication currently ordered.C. Charge nurse wi		
	1	v on 5/26/11 at 10:30 a.m.			document results of ordered	"	
		ed she had no further			bowel medication on the MA	R I	
	_	rovide and she would be			and notify MD if no results		
	1 .	education to staff			obtained following resident's		
	regarding bowel	protocol.			receipt of ordered med.D. A		
					residents will be care planne		
	2. The record of	Resident #1010 was			regarding constipation or pot for constipation.1. Current E		
	reviewed on 5/2:	5/11 at 3:55 p.m.			Management policy and		
	Diagnoses for R	esident #1010 included,			procedures have been review	wed	
	but were not lim	ited to, constipation and			and revised, including clarific		
	spinal stenosis.	•			of Procedure #7 to prevent for		
					misinterpretation.(See Bowe Management policy that was		
	A care plan with	an onset of 8/11/10 and			uploaded to this	'	
	1 -	7/14/11 indicated the			report)Completed 6/6/112. A	All I	
	L carrein unough	// 14/ 11 mulcaled the					

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247	LDING IG	NSTRUCTION 00	(X3) DATE COMPI 05/26/2	LETED
	FPROVIDER OR SUPPLIE	R	501 NO	DDRESS, CITY, STATE, ZIP CODE RTH 17TH AVENUE GROVE, IN46107	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY) nursing staff(licensed	3 NATE	(X5) COMPLETION DATE
	to decreased act she would have least every 3 day documentation i 90 days." Intervnurse will admir laxatives per [reschedule with the nurse will monit medication and name] chartThe notified and an eappropriate treat has had no documovement in 3 december of the work of an El Record for Marca Resident #1010 movement 3/12/2. Review of Media Records for Marca for Marca for Marca for Marca for Marca for Media Records for Marca for Media fo	risk for constipation due livity. The goal was that a bowel movement at ys "as seen by the in her chart within the next rentions included "The inster stool softeners or sident's name] usual e physician's order. The for the effectiveness of the document it in [resident's name] mentation of a bowel days." In the resident could receive it is (a laxative) 30 and day as needed for riginal order date 9/25/08) It imination Tracking the 2011, indicated the did not have a bowel 11 through 3/16/11. In the cation Administration arch 2011 did not indicate dived any Milk of the model in through 3/12/11 through 3/12/11 through 3/12/11 through		nursing staff(licensed nurses/CNAs) to be inserv new Bowel Management p and procedures by 6/25/11 Night charge nurses will re nightly each resident's Elin Tracking form in addition to and evening charge nurses monitor documentation and prevent deficiency recurrer Begun 6/6/114. DON and Manager will monitor Elimi Tracking form and MAR we for three (3) months. Begu 6/14/115. Deficiency and corrective measures prese QA committee on 6/21/11 and will be reviewed quarte one(1) year by DON and committee.6. All charge nowill be counseled with writt disciplinary reports by 6/25 MDS RN will review all resund develop care plan for regarding constipation/elim needs.	olicy 3. veiw hination day s to d hince. Unit hation eekly n hted to by DON erly for urses en /11.7. dents each	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15E247			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE :	ETED	
		15E247	B. WIN	IG		05/26/2	011
NAME OF	PROVIDER OR SUPPLIER	- {		1	ADDRESS, CITY, STATE, ZIP CODE		
ST PAUI	. HERMITAGE			1	RTH 17TH AVENUE GROVE, IN46107		
(X4) ID		STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	There was no do	cumentation to indicate					
	the physician ha	d been notified of the					
	resident's lack of	f bowel movements					
	during this 5 day	period.					
		ion was requested from					
	the DoN on 5/25	•					
	1 -	sident's lack of BM's or					
	treatment between	en 3/12/11 and 3/16/11.					
	During interview	y on 5/26/11 at 10:30 a m					
	During interview on 5/26/11 at 10:30 a.m. the DoN indicated she had no further						
	information to provide and she would be						
	providing some education to staff						
	regarding bowel						
	l reguraning oower	protocoi.					
	3. The record for	r Resident #779 was					
	reviewed on 5/20	6/11 at 1:30 p.m.					
	Diagnoses include	ded, but are not limited					
	to, abdominal di	scomfort secondary to					
	weak abdominal	·					
	1	condition that reduces the					
	1	to empty it's contents),					
	mild irritable bo	wel syndrome.					
	Δ recanitulated r	physicians order for May,					
	1 * *	Resident #779 had a PRN					
		r for Milk of Magnesia					
	, ,	e 30 mls by mouth, once a					
	day for constipat	•					
	au ioi constiput						
	An "Elimination	Tracking Record" for the					
	month of March	, 2011, indicated Resident					
	#779 didn't have	a bowel movement (BM)					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		15E247	B. WIN			05/26/2	011
		l .	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	8			RTH 17TH AVENUE		
ST PAUL	. HERMITAGE				GROVE, IN46107		
		CTATE ACUT OF DEPLOYED AND		ID			(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	DATE
1110		· · · · · · · · · · · · · · · · · · ·		1110			Ditte
	<u>-</u>	March 8th to March					
		d indicated the resident					
	· ·	out a BM. There were					
		ications to the physician					
	in regards to the	residents lack of bowel					
	movements or la	ck of prn medications not					
	being administer	red.					
	The "Medication	Administration Record"					
		nonth of March, 2011 was					
	, ,	MAR indicated Resident					
		eived any Milk of					
	Magnesia for co	nsupation.					
	During on intern	iow with DON on 5/26/11					
		riew with DON on 5/26/11					
	_	ther information was					
		ards to bowel movement					
	tracking. The DO	ON indicated the facility					
	was not properly	documenting bowel					
	elimination and	no other information was					
	available in rega	rds to the lack of bowel					
	movements or th						
		ng administered and					
	bowel movemen	_					
		a ducking.					
	3.1-35(g)(1)						
	J.1-JJ(8)(1)						